HEALTH ACCESS

PRELIMINARY ANALYSIS *January 17, 2007*

Gov. Schwarzenegger's Health Care Proposal

Gov. Arnold Schwarzenegger on Monday unveiled a detailed and sweeping proposal to cover all uninsured in California, emphasizing "shared responsibility" – between individuals, employers, providers, insurers, and government.

The focus of the Governor's materials are threefold:

1) Prevention, health promotion, and wellness;
2) Coverage for all Californians; and
3) Affordability and cost containment.

In particular, the Governor's proposal focuses on removing the "hidden tax" of caring for the uninsured from the cost of private health coverage, by "creating an efficient, competitive market dynamic." The governor's team estimates that his proposal could cut the "hidden tax" that average families pay ($1,186) by half.

This plan includes an individual mandate to purchase private coverage, with some public program expansions and subsidies for some low-income families, as well as rules on and contributions by employers, insurers, and providers.

According to the materials, the structure is meant to ask something of each stakeholder group, but to benefit each group as well, including insurers, providers, employers, government, and individuals. So the providers get increased Medi-Cal rates, and millions of more insured—and thus paying—patients. But the proposal then asks for a dividend back, placing a fee on providers of 2% or 4%. This financing is used to draw down federal matching funds, just one example of the proposal's interlocking parts.

CONSUMER PERSPECTIVE

Some of these provisions are proposals that consumer groups have long supported as stand-alone legislation, especially around setting rules on insurers and employers, and the expansion of public insurance programs for children and adults. But there lies significant concern about the placing of risk to the individual consumers and families, through the individual mandate as well as other components of the proposal.

This is the beginning of the legislative year, and the Governor's proposal will need to be negotiated with members of the legislature, many of whom have their own proposals. The attention to health reform, and the Governor's new consensus with legislative leaders about the need for expanded public programs, and standards for employers and insurers, suggests that there is reason for optimism.

Consumer advocates will need to be vigorous in opposing elements that are steps backward, pushing on provisions are steps forward but that don't go far enough, and keeping the urgency and visibility of this issue in the forefront, in the goal of winning reform that helps health care consumers.

STEPS FORWARD: NEW RULES ON THE HEALTH SYSTEM

Among the concepts and elements that have been supported by consumer and community advocates in the past:

- **Universality:** The plan sets the goal to ensure that all Californians have access to coverage and care, and the Governor has stated that this is his top priority this year.

- **Expansion of public programs:** The proposal does expand Medi-Cal and Healthy Families, for children and adults.
    - *POOR ADULTS:* Adults without children at home living at or below the poverty level ($9800 for an individual; $13,200 for a couple) would now qualify for Medi-Cal--an expansion of 630,000 adults.
    - *CHILDREN'S COVERAGE:* Both Medi-Cal and Healthy Families would be expanded to cover all children up to 300% of the federal poverty level ($49,800 for a family of three; $60,000 for a family of four), regardless of immigration status.
    - *SUBSIDIZED POOL:* To comply with the individual mandate, subsidies to a state purchasing pool will be provided to low-income families (101-250%) to help purchase health coverage. While such coverage would be a comprehensive benefit package (Knox/Keene plus prescription drugs with a $500 hospital deductible), there would not have the protections in public programs, including vision or dental coverage, or cost-sharing limits. The premiums charged to these low-income individuals and families will be:

% Gross income	% FPL	Income Range (Single)	Income Range (Family of 4)
3%	100-150%	$9,800-$14,700	$20,000-$30,000
4%	151-200%	$14,700-$19,600	$30,000-$40,000
6%	201-250%	$19,600-$24,500	$40,000-$50,000

      Many advocates for low-income consumers would prefer public program coverage, and at least much lower financial burdens. In addition, there is significant concern about the need for assistance for those over 250% of the FPL ($25,000 for an individual, $50,000 for a family of four.)
    - *MEDI-CAL RATE INCREASE:* The plan also proposes increasing Medi-Cal rates for providers, hospitals, and health plans, which is likely to have a positive impact for those on Medi-Cal to have access to care by these providers. Some of these increases would be tied to "pay-for-performance" measures.

- **Rules for Insurers:** The plan would make major changes to the individual insurance market, many long advocated for by consumer advocates, as a first step toward greater oversight over the insurance industry.
    - The plan would set the principle ("guaranteed issue") that nobody should be denied coverage because of their health status--so-called "pre-existing conditions."
    - A related provision ("community rating") would prevent insurers from setting different rates based on health status or anything other than age or geography.
    - Finally, the plan would require insurers to dedicate 85 cents of every premium dollar to health care. While HMOs are already required to meet that threshold (known as a "medical loss ratio"), PPOs now spend as little as 50 cents per premium dollar on actual health care.
    - There will be a mandated minimum in the open insurance market limiting deductibles to $5,000, and out-of-pocket costs to $7,500 for an individual and $10,000 for a family. While there is no out-of-pocket cost maximum now, such costs still would place a insured person in medical debt and risk for bankruptcy.

- **Employer Contribution:** The plan does require employers with 10 or more employees to contribute to the health care system, to either provide some coverage or pay 4% of the payroll. While this employer "in lieu" fee is projected to raise $1 billion as part of the plan, it does not set a standard for on-the-job health benefits. According to the March 2005 Current Population Survey, employers now spend an average of 7.2% of their total payroll on health care and slightly over 10% of the payroll of those for whom they provide coverage. (Wal-Mart, for example, which now spends 7% of payroll, would not have to increase coverage or spend any more.) Also, since the fee is assessed as a broad aggregate of health spending, and not on a per-worker basis, an employer that provided very good benefits to management or long-time workers but little or nothing to new or part-time workers could still meet this low threshold. Unless the requirement were signficantly more and differently structured, this would not provide greater security to the 19 million Californians who now get coverage through employers.

STEPS BACK: NEW RISKS FOR CONSUMERS

While the theme of the proposal is "shared responsibility," the focus of the responsibility is on individual consumers. Based on what was proposed on Monday, patients and workers bear a disproportionate amount of risk. Consumer advocates will be working to remove or mitigate these aspects of the proposal.

*** The individual mandate:** The core of the proposal--the individual mandate--is something that has been opposed by consumer groups as unwarranted, unworkable, and unwise. Unlike the many health plans supported by consumer and community groups in the last several years, which have people share--and in many cases required to share--the cost and burden of health care (at the worksite, through public programs, or through a universal system), an individual mandate places the financial and legal risk and burden of coverage on individual patients and families.

Some of the other provisions attempt to mitigate these problems, but they don't provide the protections regarding the ability to pay, or provide a defined benefit of value. Most importantly, there is concern that the individual mandate would actually undermine the group coverage that many have now, especially through employers. Health Access California has a paper regarding individual mandates at:
http://www.health-access.org/expanding/ind_mandates.htm

Under the plan, everyone must prove they have health care insurance, with some limited assistance to low-income families, but beyond that with no consideration for ability to pay. Some specific issues:

- *Unfairness:* Unlike the employer or provider contributions to this plan, which are capped and based on ability to pay, the individual burden to buy coverage is unlimited. Even the only other state to ever adopt an individual mandate, Massachusetts, included a broad exemption if coverage was unavailable or unaffordable.
- *Undermining existing coverage:* Such a dynamic--with a low and capped employer contribution, but an ongoing and unlimited individual requirement--could lead employers to continue to shift more costs into workers.
- *Enforcement:* The plan envisions using providers to help enroll and expect proof of insurance. For those that are inevitably left out, it may discourage them to get needed care. Other enforcement mechanisms include the payroll through the Employment Development Department, and then with submitting proof of coverage on tax returns. Individuals would have to prove that they have health coverage through their tax returns. If their tax records show they have not purchased coverage for the year, there would be mechanisms to either enroll qualified individuals in the subsidized pool, or auto-assign people with a private plan for which they would have to pay.
- *Impact for low-income:* Those low-income Californians that qualify for public programs would certainly be better off insured, and the mandate would simply serve as an enrollment function. But those in the state purchasing pool (adults from 100-250% of poverty), will find themselves having to pay a major amount (3-6%) of their incomes, which many consider to be unaffordable for those living on such tight budgets.

- *Biggest impact:* The most impacted are those with no subsidies, because of their income or other disqualifying criteria. They will have two choices: either they will attempt to get a good comprehensive benefit at an extremely high cost, relative to their income, or they will attempt to mere the bare minimum of the mandate by spending good money on a product of dubious value. For instance, individuals above 250% of poverty (more than $24,500 for an individual, $41,500 for a family of three, or $50,000 for a family of four) are concerned. Yet, they'd be forced to go into the market – on their own – and purchase healthcare that could amount to nearly one-fifth of their annual income. Or to just meet the requirement they have to buy a high-deductible plan that may well be a little cheaper, but still a lot of money and of little value.

* **Concern about the safety net:** The proposal takes half of the money ($2 billion) that currently goes to public hospitals to pay for their care of uninsured patients. Even with more insured people, this could provide huge problems for key public hospital that we all rely on, yet which have been chronically underfunded. For example: Kern and Monterey Counties , which have been teetering on closure; San Francisco, which relies on San Francisco General and network of clinics to administer its not-yet-implemented Health Access Program for universal access, and in Los Angeles King-Drew hospital, which has had its own set of issues, and LA County/USC Medical Center. The closure of any public hospital would be hugely damaging for all Californians, who rely on trauma centers and emergency rooms in their community to provide care when they need it.

* **A review of of health plan benefits**, provider, and procedural mandates could be a threat to key consumer protections, such as the HMO Patients' Bill of Rights. The plan also considers "the elimination of unnecessary health plan reporting requirements," which may be a concern for consumer advocates.

* **Some low-income patients may lose some protections:** While the proposal does significantly expand Med-Cal coverage, it also shifts Medi-Cal recipients (excluding pregnant women) over the poverty level ($9800 for individual, $20,000 for a family of four) to other public programs, including Healthy Families and that have some fewer benefits and protections. This would impact 680,000 children and 215,000 adults.

* **The proposal also encourages underinsurance** and high-deductible plans, by offering a state tax break for Health Savings Accounts (which are only available for high-deductible plans). While employers aren't paying enough, individuals would pay too much. The governor's plan would establish a "minimum benefit package'' requiring people who must buy insurance on their own to have at least a $5,000 deductible plan. Health Savings Account holders would get a tax credit, taking money away from state coffers to provide access to health care.

OTHER PROVISIONS

Contrary to predictions that the plan would be small or vague, the proposal also is broad and detailed (although there are some questions that are not answerable, given that it is not in legislative language.) There are other major components, including:

On prevention and wellness:
* Structuring benefits and providing incentives to promote prevention and wellness, including a "Healthy Actions" requirement on public programs and to be offered in the private market to provide rewards and incentives.
* Major efforts and campaigns to focus on diabetes, obesity, and tobacco use.
* An effort to prevent medical errors, including requiring electronic prescribing of medication by 2010 and require new reporting of health safety measures at health facilities.

On affordability and cost-containment:
* Requiring employers to provide (but not fund) a Section 125 plan so their workers can use pre-tax dollars to pay for premiums of insurance in the individual market.
* An effort to reduce "regulatory barriers," including allowing the growth of retail-based medical clinics by making scope-of-practice changes for nurse practitioners and physician assistants.
* A new "'worst first' system of hospital conformity to seismic safety requirements.
* A new "24-Hour Coverage" pilot program for CalPERS (with opt-in for private sector) to coordinate worker's compensation with traditional group health coverage.
* A major Health Information Technology effort, which includes the adoption of standardized Personal Health Records, and a major focus on tele-health and tele-medicine.

THE BEGINNING OF A RENEWED DEBATE

What the governor proposed Monday is clearly only the beginning. In his announcement, he invited several people from a range of sources, to comment and critique his proposal. The range of views was as disparate as the panelists. To view the panel and the announcement, visit the Governor's web site at: http://gov.ca.gov/index.php?/press-release/5057/

In the last few years, the California Legislature has passed major bills to expand coverage to California workers, children, and all Californians, but have seen Governor Schwarzenegger oppose them. But now that he has come forward with his own, serious proposal—whatever its merits, this provides the framework for a real debate over these issues, and the real potential for action this year.

For more information, contact Health Access: http://www.health-access.org